Acknowledgement of Receipt of Notice of Privacy Practices

THE HEARING CLINIC

I have reviewed a copy of this office's Notice of Privacy Practices:

Print Name:_____

Signature:_____

Date:_____

Consent

The Hearing Clinic may call my home or alternate number and leave a message on voicemail or with any individual designated below regarding treatment, payment, or health care operations:

[ ] YES [ ] NO

Email/text messaging allows us to communicate with you more efficiently and provide you with better service. At the same time, we recognize that even though our email is encrypted, [email/text messaging] is not a completely secure means of communication because these messages can be addressed to the wrong person or accessed improperly while in storage or during transmission.

You are not required to authorize the use of [email/text messages], however if you choose not to authorize us to send you health information over [email/text messages], we may not be able to serve you.

If you would like us to send you [email/text messages] that contain your health information, please select "Yes":

[ ] YES [ ] NO

The following individuals are designated to receive protected health information on my behalf:

Name:_____ Relation to Patient:_____

Name:_____ Relation to Patient:_____

Office use only:

[ ] Individual refused to sign

Comments: